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	085003	A. BUILDING _____ B. WING _____	C 11/22/2011

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METHODIST COUNTRY HOUSE	4830 KENNETT PIKE WILMINGTON, DE 19807

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F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from November 14, 2011 through November 22, 2011. The deficiencies contained in this report are based on observations, interviews, review of resident's records and review of other documentation as indicated. The facility census the first day of the survey was 43. The Stage II sample totaled twenty eight (28) residents	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure and promote care for two (2) residents (R16 and R36) in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of their individuality. Findings include: During a lunch observation in the assisted dining room on 11/14/11, Residents R16 and R36 ((who needed assistance with their meals) waited for 30 minutes before the staff started to feed them. There were two other residents seated with them at the same table. These 2 other residents were already eating independently while R16 and R36 were waiting.	F 241	F Tag 241 A. An audit was initiated to randomly check that residents #R16 & R36 were being fed promptly on arrival for meals. Attachment # 1. B. The above audit included all residents needing assistance and eating in the dining room. Attachment # 2. C. Staff will be educated on the need to be available and assist residents to eat, especially those who are at a table with residents who have already been served. Attachment# 3. C.N.A. meal time will be adjusted to better accommodate the residents need. Attachment # 4. An audit will continue to be completed a minimum of twice weekly on the day and evening shifts at meal time. Attachment# 5.	12/2/2011 12/23/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Jennifer White Executive Director 12/21/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure and promote care for two (2) residents (R16 and R36) in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of their individuality. Findings include: During a lunch observation in the assisted dining room on 11/14/11, Residents R16 and R36 ((who needed assistance with their meals) waited for 30 minutes before the staff started to feed them. There were two other residents seated with them at the same table. These 2 other residents were already eating independently while R16 and R36 were waiting.	F 241	D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.	1/30/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Pamela White — Executive Director — 12/21/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 This finding was discussed with E2 (DON) and E4 (RN) on 11/22/11.	F 241		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for four (R9, R62, R64 and R73) out of 28 sampled residents the facility failed to develop a care plan based on identified care needs. Findings include: 1. R73's clinical record revealed that hospice services were implemented on 10/15/11. Although the clinical record contained	F 279	F Tag 279 1-Hospice Care Plans A. Resident R73's Hospice care plan was immediately added. Attachment # 6. 11/22/2011 B. All Hospice residents' care plans were audited for an appropriate care plan. Attachment # 7. 12/2/2011 C. An audit to ensure presence of an appropriate Hospice care plan will be completed monthly on all Hospice residents. Attachment # 8. 1/30/2012 D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance. 1/30/2012	

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F 279	Continued From page 2 documentation of involvement of hospice services, the facility failed to develop a plan of care with measurable goals and interventions to address the care and treatment related to the resident's palliative and end-of-life needs, in accordance with the assessment, resident's wishes, and current standards of practice. During an interview with E4 (RN) on 11/18/11 at 2:50 PM, E4 acknowledged the lack of a Hospice care plan for R73. 2. Cross refer F315, example #1 R9 was admitted to the facility on 5/23/11. The admission Minimum Data Set (MDS) assessment, dated 6/3/11 stated this resident was continent of bladder or coded a "0." The quarterly MDS, dated 9/21/11 revealed that R9 was now coded as "1" or "occasionally incontinent (less than 7 episodes of incontinence)." Despite R9's decline in continence status, the facility failed to develop a care plan to address this decline. Findings were acknowledged by E2 (Director of Nursing) during an interview on 11/18/11. 3a. The facility failed to develop a care plan with a measurable goal and interventions to address alternative care and treatment for R 62's contracture of the ankle and foot joint to ensure provision of care, prevent decline in ROM (range of motion) abilities or improve/maintain functioning when he refused to be fitted with an orthotic related to his ROM needs.	F 279	F Tag 279 2-Continence Care Plans A. A care plan for continence was immediately completed for R9. Attachment # 9. B. All other residents in the Health Center will have their admission MDS continence status compared to their most recent MDS continence status. Any resident displaying a decline without a care plan in place will have a care plan in place to address the decline. Attachment # 10. C. The MDS coordinator will complete a quarterly continence assessment at the time of each resident's MDS . The coordinator will list any residents with a decline as indicated on the quarterly continence assessment or MDS on the Change in Continence Report (Attachment # 11) and	11/23/2011 11/30/2011

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F 279	Continued From page 2 documentation of involvement of hospice services, the facility failed to develop a plan of care with measurable goals and interventions to address the care and treatment related to the resident's palliative and end-of-life needs, in accordance with the assessment, resident's wishes, and current standards of practice. During an interview with E4 (RN) on 11/18/11 at 2:50 PM, E4 acknowledged the lack of a Hospice care plan for R73. 2. Cross refer F315, example #1 R9 was admitted to the facility on 5/23/11. The admission Minimum Data Set (MDS) assessment, dated 6/3/11 stated this resident was continent of bladder or coded a "0." The quarterly MDS, dated 9/21/11 revealed that R9 was now coded as "1" or "occasionally incontinent (less than 7 episodes of incontinence)." Despite R9's decline in continence status, the facility failed to develop a care plan to address this decline. Findings were acknowledged by E2 (Director of Nursing) during an interview on 11/18/11. 3a. The facility failed to develop a care plan with a measurable goal and interventions to address alternative care and treatment for R 62's contracture of the ankle and foot joint to ensure provision of care, prevent decline in ROM (range of motion) abilities or improve/maintain functioning when he refused to be fitted with an orthotic related to his ROM needs.	F 279	this report will be reviewed at the weekly interdisciplinary meeting. An audit will be completed after seven days of the meeting to ensure that new residents listed on the Change in Continence Report have a continence care plan in place. Attachment # 12. D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.	1/30/2012 1/30/2012

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F 279	Continued From page 2 documentation of involvement of hospice services, the facility failed to develop a plan of care with measurable goals and interventions to address the care and treatment related to the resident's palliative and end-of-life needs, in accordance with the assessment, resident's wishes, and current standards of practice. During an interview with E4 (RN) on 11/18/11 at 2:50 PM, E4 acknowledged the lack of a Hospice care plan for R73. 2. Cross refer F315, example #1 R9 was admitted to the facility on 5/23/11. The admission Minimum Data Set (MDS) assessment, dated 6/3/11 stated this resident was continent of bladder or coded a "0." The quarterly MDS, dated 9/21/11 revealed that R9 was now coded as "1" or "occasionally incontinent (less than 7 episodes of incontinence)." Despite R9's decline in continence status, the facility failed to develop a care plan to address this decline. Findings were acknowledged by E2 (Director of Nursing) during an interview on 11/18/11. 3a. The facility failed to develop a care plan with a measurable goal and interventions to address alternative care and treatment for R 62's contracture of the ankle and foot joint to ensure provision of care, prevent decline in ROM (range of motion) abilities or improve/maintain functioning when he refused to be fitted with an orthotic related to his ROM needs.	F 279	F Tag 279 3A-Contractures/Refusing Treatment A. A care plan to address alternative care and treatment for R62's contractures was put in place. Attachment # 13. B. All residents with contractures who are refusing interventions were assessed for presence of a care plan for alternative care. Attachment # 14. C. An audit of residents with contractures refusing interventions will be reviewed monthly to ensure a care plan is in place. Attachment # 15. D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.	11/18/2011 12/19/2011 1/25/2012 1/30/2012

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F 279	Continued From page 3 Review of Physical Therapy progress notes/summary revealed that foot drop was a concern and they will try to determine best course. PT Progress/Treatment Note dated 6/28/11 stated, "Decline exercise, and refuse ankle wt-"I do not want them on me". R62 was scheduled for orthotic fitting - Refused Orthotist to fit him PT Progress/Treatment note dated 7/05/11 stated, " Resident attempting to be fitted for second time with orthotist-resident refused - discharge from PT after this time Do not recommend staff walk resident due to his severe left ankle instability." R62 was observed on 11/17/11 wearing a Jobst stockings on his left lower extremity. In an interview with E4 (RN) on 11/18/2011 at 10:30 AM, she acknowledged that a care plan was not developed to implement appropriate alternative interventions related to R62's need for ROM without the orthotic to provide the needed services and to monitor and evaluate resident's response to the interventions. b. Cross-refer to F315 example 2 The facility failed to develop a comprehensive care plan for one (1) resident (R62) with bladder incontinence that included measurable objectives and timetables to meet this resident's medical and nursing needs that are identified in the comprehensive assessment. R62's bladder continence declined from "frequently incontinent (coded 2) on 6/28/11 MDS assessment to "always incontinent" (coded 3) on	F 279	F Tag 279 3B-Bladder Incontinence Care Plan A. A care plan for R62's incontinence was immediately put in place. Attachment #16. B. Other residents will have their latest and most recent MDS scores compared for decline in incontinence. Any residents with a decline will be care planned. Attachment #17. C. The MDS coordinator will complete a quarterly continence assessment at the time of each resident's MDS. The coordinator will list any residents with a decline as indicated on the quarterly continence assessment or MDS on the Change in Continence Report (Attachment #18) and this report will be reviewed at the weekly interdisciplinary meeting. An audit will be completed after seven days of	11/22/2011 11/30/2011 1/25/2012

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F 279	Continued From page 4 his quarterly MDS assessment dated 9/14/11 This finding was acknowledged by E4 (RN) on 11/22/11 at 10:30 AM 4. Cross-refer to F309 The facility failed to recognize and failed to assess factors that placed R64 at risk for skin injuries and failed to develop a care plan to define and implement specific preventative measures to the extent possible to meet R64's needs and reduce her risk for sustaining injuries such as skin tears, cuts, bruising and abrasions and others.	F 279	F Tag 279 4-Care Plan for at Risk Skin Tears A. A care plan to address R64's at risk for skin tears was immediately completed. Attachment # 20. B. An assessment for residents at risk for skin tears was completed on all residents. Attachment # 21. Using the At risk for Skin Tears Assessment Sheet. Attachment # 22. C. After each skin tear a resident will be reassessed using the At Risk for Skin Tears Assessment sheet and appropriate interventions will be put in place and care planned. An audit will be done to ensure that each resident with a skin tear is assessed and care planned as needed. Attachment # 23. Nurses will be educated on the new forms and its use. Attachment # 24.	11/20/2011 12/20/2011 1/25/2012 12/30/2011
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that one (1) resident (R64) received the care and services to attain or maintain her highest physical well-being in accordance with the comprehensive assessment. R64 had multiple episodes of witnessed and/or unwitnessed incidents with resulting skin injuries. Findings include: R64 had diagnoses of COPD (Chronic obstructive	F 309		

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F 279	Continued From page 4 his quarterly MDS assessment dated 9/14/11 This finding was acknowledged by E4 (RN) on 11/22/11 at 10:30 AM 4. Cross-refer to F309 The facility failed to recognize and failed to assess factors that placed R64 at risk for skin injuries and failed to develop a care plan to define and implement specific preventative measures to the extent possible to meet R64's needs and reduce her risk for sustaining injuries such as skin tears, cuts, bruising and abrasions and others.	F 279	D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.	1/30/2012
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that one (1) resident (R64) received the care and services to attain or maintain her highest physical well-being in accordance with the comprehensive assessment. R64 had multiple episodes of witnessed and/or unwitnessed incidents with resulting skin injuries. Findings include: R64 had diagnoses of COPD (Chronic obstructive	F 309		

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F 309	Continued From page 5 pulmonary disease), anxiety, asthma, debility unspecified, Chronic airway obstruction, macular degeneration, (legally blind) osteoarthrosis, osteoporosis and hearing loss. According to R64's nursing Resident Admission Assessment dated 5/19/11, she was alert and oriented to person and place, legally blind and wore a hearing aid. She was fearful, tearful, combative (yelling) and verbally abusive. According to R64's admission Minimum Data Set (MDS) assessment dated 5/31/11, this resident's BIMS (Brief Interview of Mental Status) score was 10 (13-15 cognitively intact; 8-12 moderately impaired; 0-7 severely impaired). R64 was independent in all Activities of Daily Living (ADLs) and was not at risk for pressure sores. According to R64's quarterly MDS assessment dated 9/22/11, her BIMS score was 7, indicating a decline in her mental status. However, she remained independent with all ADLs, ambulated with a walker and remained at no risk for developing pressure sores. R64 was admitted to the facility on 5/19/11 with "scab to (L) outer wrist and (L) knee; top of her nose; shins ecchymotic and bone to great toe joint was pink but resident was wearing shoes without socks". Additionally, a nurse's note dated 5/20/11 stated there was an "open area with fresh blood noted to (L) knee measuring 1.3 cm x 0.1 cm "Left knee scabbed area must have reopened with friction. Resident was unsure of when/how wound occurred". R64's medications included Lasix oral tab 60 (20 + 40mg) mg 1 tab PO (by mouth) once a day at 8:00 AM for edema of the lower extremities and	F 309	F Tag 309 A. An assessment of R64 skin using the At Risk for Skin Tear Assessment and a resulting care plan were done immediately. Attachment # 25 and # 26. B. An assessment for all residents at risk for skin tears was completed. Attachment # 27. C. After each skin tear a resident will be reassessed using the At Risk for Skin Tear Assessment and appropriate intervention will be put in place and care planned. An audit will be done to ensure that each resident with a skin tear is assessed and care planned as needed. Attachment # 28. D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.	11/20/2011 12/20/2011 1/25/2012 1/30/2012

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F 309	Continued From page 6 Prednisone oral tab 5 mg 1 tab by mouth once a day for-COPD (chronic obstructive pulmonary disease). Review of R64's record revealed that this resident was prone to skin tears/bruises/abrasions/other injuries due to a known or unknown causes. R64's record revealed the following episodes of events: a. A nurse's note dated 7/27/11 stated, "At 1445 Resident rang her call light and resident noted to have a 3 cm skin tear to (L) anterior forearm. Resident said,"I was in a hurry to get to the bathroom and hit my arm on something sharp in the doorway. Nothing sharp noted in the doorway." The skin tear was treated with Opsite dressing per physician's order and was to be treated with same opsite dressing every 3 days until the (L) anterior skin tear healed. IDT's (Interdisciplinary Team) review of the resident's skin tear on 7/29/11 revealed that Resident was getting up from the toilet using handrails when her left hand slipped and she slipped into the wall causing the skin tear. b. A nurse's note dated 8/12/11 stated, "Resident has blood blister to(R) anterior foot. Resident stated" it was due to her shoe being too tight" applied opsite to prevent blister from opening. c. A nurses's notes dated 8/31/11stated ..." Shins slightly ...red". d. A nurse's note dated 9/11/11 stated, "Called to see resident's legs,both feet have a +1 edema....both calves are warm swollen +2 edema, bruised and red areas present..tender	F 309		

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F 309	Continued From page 7 spots on both calves extremely painful to touch. Air pockets noted over some reddened areas. 9/12/11on palpations legs are lumpy..(L) leg has abrasions to the anterior portion....". A nurse's note dated 9/13/11 stated, left leg with scab on the shin and pink areas. There is a scab to right anterior foot. e. A nurse's note dated 10/12/11 stated at 1715 (5:15 PM) Resident sustained bruise (L) knee 3 cm x 2cm with slight skin tear when bumped by another resident in wheelchair trying to make space for resident to pass by, area was cleansed and bandaid applied----10/13/11 "bruising noted to area..slight discomfort upper shin area". f. A nurse's note dated 10/19/11stated, "...She did cut her right face while shaving. Cleansed with normal saline. Applied dry dressing until bleeding stopped". g. A nurse's note dated 11/11/11 stated, "..at 0245, this nurse was called into Resident's room to assess a bleeding area on her(L) leg. Upon assessment a 1.2 cm x1.1 cm skin tear was noted on the (L) lateral calf area. Wound was oozing a moderate amount of bright red blood. Pressure applied to area to stop the bleed then she was cleaned with SAF-clens ...then NSS (normal saline). Dried blood on rest of the leg was also cleansed with warm/wet cloth. Bacitracin ointment applied and area covered with non-adherent dressing h. A nurse's note dated 11/12/11stated, "Scratching legs and scant blood noted. Applied dry dressing to (L) lower shin	F 309		

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F 309	Continued From page 8 i. A nurse's note dated 11/15/11 stated, "Resident still scratches her very dry leg and this AM she said I scratched off a scab from her left calf, cleanse the open area and applied dry dressing for protection". The facility failed to recognize and assess factors that placed R64 at risk for skin injuries and failed to provide services to the extent possible to meet R64's physical needs and reduce her risk for sustaining skin tears, bruising, abrasions and other injuries. This finding was discussed with E2 (DON) and E4(RN) on 11/22/11 prior to the survey exit.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview and review of facility documents, it was determined that the facility failed to ensure that a resident who was incontinent of bladder received appropriate treatment and services to restore as	F 315	F Tag 315 A. R9 and R62 were immediately reassessed (Attachment # 29) and a voiding diary started. Attachment # 30 . Care plans are Attachment # 30a . B. All other incontinent residents will have their Bowel and Bladder Training Assessment (Attachment # 31) audited for completion. Using information from these assessments, a decision will be made which residents will need a voiding diary and care plan completed.	12/20/2011 12/20/2011

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F 315	Continued From page 9 much normal bladder function as possible for two (R9 and R62) out of 28 sampled residents. The facility failed to accurately assess R9's and R62's continence status and failed to evaluate their status using a voiding dairy in order to determine voiding patterns and care plan accordingly . Findings include: The facility's policy and procedure entitled "Bowel and Bladder Maintenance" stated: "1. Every resident is assessed for bowel and bladder continence on admission using the Bowel and Bladder Training Assessment form. 2. If a resident is incontinent on admission and is using or needs incontinence protection, the resident is measured by the nurse using the Steps to (sic) measuring for TENA briefs worksheet. 3. Residents are put on a toileting plan for toileting times of before and after meals, twice in the evening and as needed/allowed by the resident during the night time hours. 4. Residents are observed on-going by aides and nurses to determine special toileting time needs of the individual resident and those times are care planned. 5. Resident's individual toileting times are indicated on the daily assignment sheets for the assigned aides. 6. The plan of care, to include level of continence and any continence changes in the resident's toileting, is reviewed with the resident and family at the quarterly care conference where adjustments can be made." 1. R9 was admitted to the facility on 5/23/11 with diagnoses that included left great toe osteomyelitis (inflammation of the bone due to infection), polymyalgia rheumatica (disorder of muscles and joints characterized by pain and stiffness), chronic back pain and overactive	F 315	C. New admissions will be audited for a complete Bowel and Bladder Training Assessment and a toileting diary completed as needed. Attachment # 32. Admitting nurses will be educated on the need to complete the assessment form on a resident's admission. Attachment # 33. D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.	1/25/2012 1/30/2012

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F 315	Continued From page 10 bladder. The "Resident Admission Assessment," dated 5/23/11 checked off that R9 was both continent and incontinent of bladder. There was no additional data documented, such as whether the resident had any frequency, dribbling or uses pads. A "Bowel or Bladder Training Assessment" dated 5/23/11 stated R9's general health was declining and that she was continent of urine "most of day" resulting in a total score equal to "6" (score 0-6: Good candidate for individual training). There was no completion of a voiding diary at this time to determine R9's voiding patterns. The admission Minimum Data Set (MDS) assessment, dated 6/3/11 stated that R9 was cognitively intact and required limited assistance of one staff person for transfers. This same MDS assessment stated R9 was independent for toilet use and was continent of bladder (coded "0"). R9 was admitted to the hospital from 6/28/11 through 6/30/11. Re-admission orders, dated 6/30/11 included orders for daily administration of Lasix (water pill) 20 mg and Detrol LA 2 mg (for overactive bladder). A quarterly MDS assessment, dated 9/21/11 stated R9 was cognitively intact and required limited assistance of one staff person for transfer and toilet use. The 9/21/11 MDS assessment stated R9 was occasionally incontinent of bladder (less than 7 episodes of incontinence-coded "1") and was not currently on a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) to manage urinary continence. The facility failed to identify and address R9's decline	F 315		

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F 315	Continued From page 11 in continence. The facility failed to assess R9's voiding patterns, failed to identify any patterns of incontinence and subsequently failed to care plan for the incontinence. A quarterly "Bowel or Bladder Training Assessment," completed on 9/23/11 stated that R9 was always continent of urine, despite the 9/21/11 MDS stating she was occasionally incontinent. Review of R9's "CORP-Continence Detail Report" (compiled from data entered by Certified Nurse Aides) from 6/1/11 through 11/21/11 revealed the following: - month of 6/11: 10 episodes of incontinence. - month of 7/11: 14 episodes of incontinence. - month of 8/11: 19 episodes of incontinence. - month of 9/11: 12 episodes of incontinence. - month of 10/11: 9 episodes of incontinence. - 11/1/11 through 11/21/11: 7 episodes of incontinence. On 11/18/11 at 12:00 PM, R9 stated that she had an overactive bladder and started the Detrol because she had been getting up all night to use the bathroom. R9 also stated that she has needed to use an incontinence pad for over a year now. During an interview on 11/18/11 at 2:20PM with E13 (CNA), she stated that she had been working with R9 since her arrival to the facility. E13 stated initially R9 wore briefs and required more assistance in toileting, but now wears an incontinence pad and can toilet herself. She stated that R9 is occasionally incontinent. When asked how she knows a resident who toilets	F 315		

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F 315	Continued From page 12 themselves is incontinent she stated that if a wet pad or brief are found in the trash can, housekeeping staff does not empty the trash, the CNAs do. E13 stated that she may have found wet pads in R9's trash can at times. In conclusion, the facility failed to accurately assess R9's continence status, failed to complete a voiding diary to determine any patterns of urinary incontinence and failed to care plan accordingly. The facility failed to ensure that R9 who was incontinent of bladder received appropriate treatment and services to restore as much normal bladder function as possible. During an interview with E2 on 11/18/11 at approximately 4:30 PM, she acknowledged the findings. 2. R62 was re-admitted from the hospital on 6/17/11 with diagnoses of change in mental status, status post (S/P) fracture of hip, Difficulty in Walking, Contracture of ankle and foot joint, paralysis Agitans, Parkinson's Disease, Pain in joint involving ankle and foot, Osteorthrosis, generalized involving multiple sites, Muscle Weakness and Dementia with behavioral disturbances. According to R62's Minimum Data Set (MDS) re-entry assessment dated 6/28/11, his BIMS (Brief Interview of Mental Status) score was 8 out of 15. R62 was assessed as frequently incontinent (coded 2 with 7 episodes or more of urine incontinence but at least one episode of urine	F 315		

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F 315	Continued From page 13 continent) of bladder. R62 needed extensive assistance of one staff member for transfers and toileting and all other activities of daily living (ADLs) except eating. The re-entry MDS assessment dated 6/28/11 reflected that a trial of a Toileting Program had been attempted with no improvement. In an interview with E4 (RN Unit Manager) on 11/18/2011 @11:15 AM, she stated that there was no trial attempted on admission/reentry for a toileting program due to progression of R62's disease. However, review of R62's clinical record lacked documentation of a completed "Bladder Training Assessment Form" as per facility's system to identify residents who are potential candidates for retraining/maintenance of bladder. Additionally, the facility did not initiate a care plan to address R62's incontinence and /or identified that this resident was a potential candidate, that was to be put on a toileting plan for toileting times of before and after meals, twice in the evening and as needed to determine his special toileting time needs per facility's procedure. According to the facility's system of bladder maintenance, these toileting times should be care planned for. In an interview with E4 (RN) on 11/22/11@10:30 AM, she acknowledged that the CNAs were documenting that the resident was incontinent daily on the CNAs care tracker. However, review of R62's CNAs "Resident ...Bladder by Shift Chart revealed the following:June 1-30/2011 R62 was continent of bladder 17 times. Subsequently, according to R62's quarterly MDS assessment dated 9/14/11 R62's cognition had improved with a BIMS score of 10 out of 15.	F 315		

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F 315	Continued From page 14 Review of the CNAs bladder care tracker dated 9/1/11 thru 9/30/11 revealed that R62 was continent 9 times. However, according to his quarterly MDS assessment dated 9/14/11, R62's bladder continence declined to "always incontinent" (coded 3). R62's CNAs bladder care tracker for 10/01/11 thru 10/30/11 revealed documentation that resident was continent 7 times and the 11/01/11 - 11/17/11 R62 was continent 9 times. In an interview with E11 (CNA) on 11/18/2011 at 3:15 PM, she stated that R62 needed 2 staff members for assistance to transfer from bed to his wheelchair and to toilet. R62 did not use the Hoyer lift to transfer. She further stated that R62 helped himself while being supported by the staff by holding on to the staff/bar for support . E11 (CNA) also stated that "if I ask him if he wanted to use the toilet, he would respond yes and if he didn't have to go, he would say no. At times he would request to go and he was always continent when he used the toilet". Interview with E12 (CNA) on 11/22/11 at 10:15 AM, she stated that R62 "could be prompted to use the toilet with assistance of one staff and claimed that she had never seen this resident incontinent when prompted to use the bathroom usually before breakfast, after breakfast and after lunch on my shift. When I am late, that's when he sometimes gets wet before he reaches the toilet". It was observed on 11/22/11 at 10:00 AM that R62 was very cooperative when prompted to use the toilet. The facility failed to attempt a trial of a Toileting Program to identify R62's potential for bladder	F 315		

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F 315	Continued From page 15 retraining/maintenance and to prevent a decline in bladder function to the extent as possible.	F 315		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to prepare, distribute and serve food to residents under sanitary conditions in the kitchen. Findings include: 1. Observation of the kitchen on 11/14/11 @8:40AM with E6 (Dietary/Utility Supervisor) and E7 (Dietary Assistant and Person-in-Charge of the kitchen at the time of the inspection) revealed the inside of the walk-in refrigerator had no temperature gauge. On 11/14/11, an interview with E6 and E7 confirmed this finding. 2. Observation of the kitchen on 11/14/11 at 8:45AM with E7 revealed that two of three paper towel dispensers were empty for the dietary staff hand sinks in the kitchen. On 11/14/11, an interview with E7 confirmed this finding.	F 371	Culinary F371-Sanitary Condition in Kitchen A. A thermometer/gauge was placed in the walk-in refrigerator B. There were no residents identified as affected by the absence of the thermometer. C. The presence of a thermometer in the walk-in refrigerator will be audited weekly. Attachment # 34. D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.	11/15/2011 1/30/2012

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F 315	Continued From page 15 retraining/maintenance and to prevent a decline in bladder function to the extent as possible.	F 315		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to prepare, distribute and serve food to residents under sanitary conditions in the kitchen. Findings include: 1. Observation of the kitchen on 11/14/11 @8:40AM with E6 (Dietary/Utility Supervisor) and E7 (Dietary Assistant and Person-in-Charge of the kitchen at the time of the inspection) revealed the inside of the walk-in refrigerator had no temperature gauge. On 11/14/11, an interview with E6 and E7 confirmed this finding. 2. Observation of the kitchen on 11/14/11 at 8:45AM with E7 revealed that two of three paper towel dispensers were empty for the dietary staff hand sinks in the kitchen. On 11/14/11, an interview with E7 confirmed this finding.	F 371	F Tag 371 Paper Towels A. Paper towels were immediately placed in all dispensers at hand sinks in the kitchen.' B. There were no residents identified as affected by the absence of paper towels. C. The presence of paper towels at hand sinks will be audited daily. Attachment # 35 . D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.	11/15/2011 1/30/2012

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F 371	Continued From page 16 3. Review of Dietary Employee health forms revealed that the facility failed to review if newly hired dietary employees (E6 and E7) for the Norovirus illness, which would prevent employees from working with food. The dietary employee health forms did not address if the staff had the Norovirus illness when they were first hired which could have prevented the dietary staff from working with food served to residents. E6 was hired on 1/27/07. E7 was hired on 01/5/11. E9 ((Director of Culinary & Nutrition Services) and E10 (Human Resource/ Business Services Specialist)) confirmed these findings on 11/22/11 respectively.	F 371	F Tag 371 Norovirus A. The two employees, E6 and E7, were assessed to presence of Norovirus symptoms. Attachment # 36.	12/17/2011
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and interviews it was determined that the facility failed to keep the compactor that was storing garbage and refuse, tightly covered to prevent pest harborage. Findings include: Observations on 11/14/11 at 9:00 AM of the compactor area outside the kitchen with E6 (Dietary Utility Supervisor) and E7 (Dietary Assistant) revealed that the side door was open to the refuse compactor and that numerous gnats were observed feeding from the garbage on the compactor. Observations were also made of encrusted food debris on the edge of the door of the compactor.	F 372	B. There were no residents identified as affected by the lack of Norovirus that were identified. C. The employee health assessment form has been replaced with a new form titled "Conditional Employee and Food Employee Interview". Attachment # 37. An audit will be performed monthly on all newly hired dietary to ensure an assessment is completed for Norovirus. Attachment # 38. D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.	1/25/2012 1/30/2012

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F 371	Continued From page 16 3. Review of Dietary Employee health forms revealed that the facility failed to review if newly hired dietary employees (E6 and E7) for the Norovirus illness, which would prevent employees from working with food. The dietary employee health forms did not address if the staff had the Norovirus illness when they were first hired which could have prevented the dietary staff from working with food served to residents. E6 was hired on 1/27/07. E7 was hired on 01/5/11. E9 ((Director of Culinary & Nutrition Services) and E10 (Human Resource/ Business Services Specialist)) confirmed these findings on 11/22/11 respectively.	F 371		
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and interviews it was determined that the facility failed to keep the compactor that was storing garbage and refuse, tightly covered to prevent pest harborage. Findings include: Observations on 11/14/11 at 9:00 AM of the compactor area outside the kitchen with E6 (Dietary Utility Supervisor) and E7 (Dietary Assistant) revealed that the side door was open to the refuse compactor and that numerous gnats were observed feeding from the garbage on the compactor. Observations were also made of encrusted food debris on the edge of the door of the compactor.	F 372	F Tag 372 Garbage/Refuse Disposal A. The compactor side door was cleaned and closed. B. No residents affected by the open compactor could be identified. C. An audit will be done daily to ensure the compactor door is clean and closed. Attachment # 39. D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.	11/15/2011 1/30/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085003	A. BUILDING _____ B. WING _____	C 11/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST COUNTRY HOUSE	4830 KENNETT PIKE WILMINGTON, DE 19807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 372	Continued From page 17 Interview with E7 on 11/14/11 confirmed this finding.	F 372		
F 456 SS=B	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on an observation and staff interviews, it was determined that the facility failed to maintain a kitchen dishwasher in a safe operating condition. Findings include: On 11/14/11 at 8:30 AM, during a tour of the kitchen area with E7 (Dietary Assistant), an observation of the dishwasher in operation at the time revealed a stream of hot water streaming out of the pipe located in the back, top of the dishwasher. The hot water was at a temperature of about 180 degrees Fahrenheit. This caused a potential for injury to employees due to scalding. Wet paper towels were observed around the area of the leaky pipe and the front of the dishwasher unit. In an interview with E7 on 11/14/11, he confirmed this finding. In an interview with E9 (Director of Culinary & Nutrition Services) on 11/14/11 at 11:20 AM, he stated the pipe was repaired.	F 456	F Tag 456 Kitchen Dishwasher Unsafe Operation A. The dishwasher was repaired. Attachment # 40. B. There have been no reported incidents of employees involving the dishwasher. C. An audit will be done daily to ensure the dishwasher is functioning safely. Attachment # 41. D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.	11/14/2011 1/30/2012

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STATE SURVEY REPORT

NAME OF FACILITY: Methodist Country House

DATE SURVEY COMPLETED: November 22, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from November 14, 2011 through November 22, 2011. The deficiencies contained in this report are based on observations, interviews, review of resident's records and review of other documentation as indicated. The facility census the first day of the survey was 43. The Stage II sample residents totaled twenty eight (28) residents	F Tag 241 A. An audit was initiated to randomly check that residents #R16 & R36 were being fed promptly on arrival for meals. Attachment # 1. B. The above audit included all residents needing assistance and eating in the dining room. Attachment # 2. C. Staff will be educated on the need to be available and assist residents to eat, especially those who are at a table with residents who have already been served. Attachment# 3. C.N.A. meal time will be adjusted to better accommodate the residents need. Attachment # 4. An audit will continue to be completed a minimum of twice weekly on the day and evening shifts at meal time. Attachment# 5. D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 11/22/11, F241, F279, F309,	

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
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3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 11/22/11, F241, F279, F309,	

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3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 11/22/11, F241, F279, F309,	

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	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from November 14, 2011 through November 22, 2011. The deficiencies contained in this report are based on observations, interviews, review of resident's records and review of other documentation as indicated. The facility census the first day of the survey was 43. The Stage II sample residents totaled twenty eight (28) residents	be reviewed at the weekly interdisciplinary meeting. An audit will be completed after seven days of the meeting to ensure that new residents listed on the Change in Continence Report have a continence care plan in place. Attachment # 12. D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 11/22/11, F241, F279, F309,	

Provider's Signature Jennie White Title Executive Director Date 12/21/11

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
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3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 11/22/11, F241, F279, F309,	

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3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 11/22/11, F241, F279, F309,	

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3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 11/22/11, F241, F279, F309,	

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3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 11/22/11, F241, F279, F309,	

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	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from November 14, 2011 through November 22, 2011. The deficiencies contained in this report are based on observations, interviews, review of resident's records and review of other documentation as indicated. The facility census the first day of the survey was 43. The Stage II sample residents totaled twenty eight (28) residents	D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 11/22/11, F241, F279, F309,	

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3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 11/22/11, F241, F279, F309,	

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3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 11/22/11, F241, F279, F309,	F Tag 315 A. R9 and R62 were immediately reassessed (Attachment # 29) and a voiding diary started. Attachment # 30 . Care plans are Attachment # 30a . B. All other incontinent residents will have their Bowel and Bladder Training Assessment (Attachment # 31) audited for completion. Using information from these assessments, a decision will be made which residents will need a voiding diary and care plan completed. C. New admissions will be audited for a complete Bowel and Bladder Training Assessment and a toileting diary completed as needed. Attachment # 32 . Admitting nurses will be educated on the need to complete the assessment form on a resident's admission. Attachment # 33 . D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.

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	F315, F371, F372, and F456.	
3201.7.5	**Kitchen and Food Storage Areas. Facilities shall comply with the Delaware Food Code.** **This requirement was not met as evidenced by:** Based on the dietary observation during the survey, it was determined that the facility failed to comply with sections: 2-201.11, 4-204.112, 4-501.11, 5-501.15, and 6-301.12 of the State of Delaware Food Code. Findings include: **2-201.11 Responsibility of Permit Holder, Person in Charge, and Conditional Employees.** **(A) The PERMIT HOLDER shall require FOOD EMPLOYEES and CONDITIONAL EMPLOYEES to report to the PERSON IN CHARGE information about their health and activities as they relate to diseases that are transmissible through FOOD. A FOOD EMPLOYEE or CONDITIONAL EMPLOYEE shall report the information in a manner that allows the PERSON IN CHARGE to reduce the RISK of foodborne disease transmission, including providing necessary additional information, such as the date of onset of symptoms and an illness, or of a diagnosis without symptoms, if the FOOD EMPLOYEE or CONDITIONAL EMPLOYEE:** ***reportable symptoms*** **(1) Has any of the following symptoms:** **(a) Vomiting,** **(b) Diarrhea,** **(c) Jaundice,** **(d) Sore throat with fever, or** **(e) A lesion containing pus such as a boil**	F Tag 371 Norovirus A. The two employees, E6 and E7, were assessed to presence of Norovirus symptoms. Attachment # 36. B. There were no residents identified as affected by the lack of Norovirus that were identified. C. The employee health assessment form has been replaced with a new form titled "Conditional Employee and Food Employee Interview". Attachment # 37. An audit will be performed monthly on all newly hired dietary to ensure an assessment is completed for Norovirus. Attachment # 38. D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.

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	or infected wound that is open or draining and is: (i) On the hands or wrists, *unless an impermeable cover such as a finger cot or stall protects the lesion and a SINGLE-USE glove is worn over the impermeable cover,* (ii) On exposed portions of the arms, *unless the lesion is protected by an impermeable cover,* or (iii) On other parts of the body, *unless the lesion is covered by a dry, durable, tight-fitting bandage; reportable diagnosis* (2) Has an illness diagnosed by a HEALTH PRACTITIONER due to: (a) Norovirus, (b) Hepatitis A virus, (c) *Shigella* spp., (d) ENTEROHEMORRHAGIC or SHIGA TOXIN-PRODUCING *ESCHERICHIA COLI,*P or (e) *Salmonella* Typhi; *reportable past illness* (3) Had a previous illness, diagnosed by a HEALTH PRACTITIONER, within the past 3 months due to *Salmonella* Typhi, without having received antibiotic therapy, as determined by a HEALTH PRACTITIONER;P *reportable history of exposure* (4) Has been exposed to, or is the suspected source of, a CONFIRMED DISEASE OUTBREAK, because the FOOD EMPLOYEE or CONDITIONAL EMPLOYEE consumed or prepared FOOD implicated in the outbreak, or consumed FOOD at an event prepared by a PERSON who is infected or ill with: (a) Norovirus within the past 48 hours of the last exposure, (b) ENTEROHEMORRHAGIC or SHIGA TOXIN-PRODUCING *ESCHERICHIA COLI, or Shigella* spp. within the past 3 days of the last exposure,	

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	(c) *Salmonella* Typhi within the past 14 days of the last exposure, or **(d) Hepatitis A virus within the past 30 days of the last exposure; or** ***Reportable history of exposure*** **(5) Has been exposed by attending or working in a setting where there is a CONFIRMED DISEASE OUTBREAK, or living in the same household as, and has knowledge about, an individual who works or attends a setting where there is a CONFIRMED** **(E) A FOOD EMPLOYEE or CONDITIONAL EMPLOYEE shall report to the PERSON IN CHARGE the information as specified under ¶ (A) of this section.** ***responsibility of food employees to comply*** **(F) A FOOD EMPLOYEE shall:** **(1) Comply with an EXCLUSION as specified under ¶¶ 2-201.12(A) - (C) and Subparagraphs 2-201.12(D)(1),(E)(1), (F)(1), or (G)(1) and with the provisions specified under ¶¶ 2-201.13(A) - (G); or** **(2) Comply with a RESTRICTION as specified under Subparagraphs 2-201.12(D)(2), (E)(2), (F)(2), (G)(2), or ¶¶ 2-201.12 (H) or (I) and comply with the provisions specified under ¶¶ 2-201.13(D) - (I).** **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 11/22/11, F371, example 3. **4-204.112 Temperature Measuring Devices.** **(A) In a mechanically refrigerated or hot food storage unit, the sensor of a temperature measuring device shall be**	

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	located to measure the air temperature or a simulated product temperature in the warmest part of a mechanically refrigerated unit and in the coolest part of a hot food storage unit. **(B) Except as specified in ¶ (C) of this section, cold or hot holding equipment used for potentially hazardous food (time/temperature control for safety food) shall be designed to include and shall be equipped with at least one integral or permanently affixed temperature measuring device that is located to allow easy viewing of the device's temperature display.** This requirement was not met as evidenced by: Cross refer to the CMS 2567-L survey report date completed 11/22/11, F371, Example 1. **5-205.15 System Maintained in Good Repair.** **A PLUMBING SYSTEM shall be:** **(A) Repaired according to LAW; and** **(B) Maintained in good repair.** This requirement was not met as evidenced by: Cross refer to the CMS 2567-L survey report date completed 11/22/11, F456. **5-501.15 Outside Receptacles.** **(A) Receptacles and waste handling units for REFUSE, recyclables, and returnables used with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers.** **(B) Receptacles and waste handling units**	Culinary F371-Sanitary Condition in Kitchen A. A thermometer/gauge was placed in the walk-in refrigerator B. There were no residents identified as affected by the absence of the thermometer. C. The presence of a thermometer in the walk-in refrigerator will be audited weekly. Attachment # 34. D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.

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	located to measure the air temperature or a simulated product temperature in the warmest part of a mechanically refrigerated unit and in the coolest part of a hot food storage unit. **(B) Except as specified in ¶ (C) of this section, cold or hot holding equipment used for potentially hazardous food (time/temperature control for safety food) shall be designed to include and shall be equipped with at least one integral or permanently affixed temperature measuring device that is located to allow easy viewing of the device's temperature display.** This requirement was not met as evidenced by: Cross refer to the CMS 2567-L survey report date completed 11/22/11, F371, Example 1. **5-205.15 System Maintained in Good Repair.** **A PLUMBING SYSTEM shall be:** **(A) Repaired according to LAW; and** **(B) Maintained in good repair.** This requirement was not met as evidenced by: Cross refer to the CMS 2567-L survey report date completed 11/22/11, F456. **5-501.15 Outside Receptacles.** **(A) Receptacles and waste handling units for REFUSE, recyclables, and returnables used with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers.** **(B) Receptacles and waste handling units**	F Tag 456 Kitchen Dishwasher Unsafe Operation A. The dishwasher was repaired. Attachment # 40. B. There have been no reported incidents of employees involving the dishwasher. C. An audit will be done daily to ensure the dishwasher is functioning safely. Attachment # 41. D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.

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	for REFUSE and recyclables such as an on-site compactor shall be installed so that accumulation of debris and insect and rodent attraction and harborage are minimized and effective cleaning is facilitated around and, if the unit is not installed flush with the base pad, under the unit. **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 11/22/11, F372. **6-301.12 Hand Drying Provision.** **Each HANDWASHING SINK or group of adjacent HANDWASHING SINKS shall be provided with:** **(A) Individual, disposable towels;** **(B) A continuous towel system that supplies the user with a clean towel; or** **(C) A heated-air hand drying device; or** **(D) A hand drying device that employs an air-knife system that delivers high velocity, pressurized air at ambient temperatures.** **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 11/22/11, F371, example 2.	F Tag 372 Garbage/Refuse Disposal A. The compactor side door was cleaned and closed. B. No residents affected by the open compactor could be identified. C. An audit will be done daily to ensure the compactor door is clean and closed. Attachment # 39. D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.

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	for REFUSE and recyclables such as an on-site compactor shall be installed so that accumulation of debris and insect and rodent attraction and harborage are minimized and effective cleaning is facilitated around and, if the unit is not installed flush with the base pad, under the unit. **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 11/22/11, F372. **6-301.12 Hand Drying Provision.** **Each HANDWASHING SINK or group of adjacent HANDWASHING SINKS shall be provided with:** **(A) Individual, disposable towels;** **(B) A continuous towel system that supplies the user with a clean towel; or** **(C) A heated-air hand drying device; or** **(D) A hand drying device that employs an air-knife system that delivers high velocity, pressurized air at ambient temperatures.** **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 11/22/11, F371, example 2.	F Tag 371 Paper Towels A. Paper towels were immediately placed in all dispensers at hand sinks in the kitchen.' B. There were no residents identified as affected by the absence of paper towels. C. The presence of paper towels at hand sinks will be audited daily. Attachment # 35. D. The results of the audit will be reported at the monthly/quarterly QI meeting to the DON beginning January 2012, to ensure compliance.